



# CONNECTICUT VACCINE PROGRAM (CVP)

## Patient Eligibility Screening Record

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Provider: \_\_\_\_\_

This child qualifies for immunization through the Connecticut Vaccine Program since he/she is under 19 years of age and (check only one box):

VFC eligible:

- (A) Is enrolled in Medicaid (HUSKY A) ☐
- (B) Has no health insurance/self-pay ☐
- (C) Is American Indian or Alaskan Native ☐
- (D) Is under-insured (has health insurance that does not cover vaccines or only covers select vaccines) and is a patient of a Federally Qualified Health Center (FQHC). These patients can receive all vaccines at their FQHC. ☐

State eligible:

- (E) Is under-insured (has health insurance that does not cover vaccines or only covers select vaccines) and is a patient of a private health care provider. These patients can receive all vaccines at their private health care provider's office. ☐
- (F) Is enrolled in S-CHIP (HUSKY B) ☐
- (G) \*Is Privately Insured ☐

\*Note private insurance patients can receive all vaccines from the CVP except for Rotavirus, Human Papillomavirus Vaccine (HPV), Influenza for 5 through 18 year olds, and Hepatitis A for 2 through 18 year olds; these vaccines are only available for patients in categories A, B, C, D, E & F.

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age and younger who receive vaccine from the CVP. The record may be completed by the parent, guardian, or individual of record, or by the healthcare provider. The record does not have to be updated unless the status of the child has changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine.

Patient Eligibility must be verified and documented for **every immunization visit**. Please document that eligibility screening was verified with the initials of the person who performed the screening. If the screening result above (A-G) changed, please complete a new patient eligibility screening record.

Date of screening (mo/day/year)	Initials

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